Adopt Part Ins 1906, to read as follows:

PART Ins 1906 DISCONTINUANCE AND REPLACEMENT OF GROUP ACCIDENT AND HEALTH COVERAGE

Ins 1906.01 Scope. This section is applicable to all insurance policies and subscriber contracts issued or provided by a carrier on a group or group-type basis.

Ins 1906.02 Definitions. For the purposes of this section the following definitions shall apply:

(a) "Active recipient of mental health services" means an insured, subscriber or member of a replacing carrier's health insurance benefit plan who received mental health services from a mental health provider while covered by the prior carrier's benefit plan provided such services were received for a purpose other than monitoring medications and were received at least as often as:

(1) In the case of outpatient services:

a. For 2 separate days during the 30 day period immediately prior to the effective date of the replacing carrier's plan; or

b. For 3 separate days during the 90 day period immediately prior to the effective date of the replacing carrier's plan; or

c. For 5 separate days during the 12 month period immediately preceding the effective date of the replacing carrier's plan; and

(2) In the case of inpatient services, one impatient confinement during the 12 month period immediately prior to the effective date of the replacing carrier's plan.

(b) "Carrier" means a person or an entity that offers or provides a policy, contract or certificate of insurance coverage in this state.

(c) "Carrier" includes an insurer, a health maintenance organization, a nonprofit service corporation or any other person or entity providing a policy, contract or certificate of insurance coverage subject to state insurance regulation.

(d) "Group-type basis" means a benefit plan, other than a "salary budget" plan utilizing individual insurance policies or subscriber contracts, which meets the following conditions:

(1) Coverage is provided through insurance policies or subscriber contracts to classes of employees or members defined in terms of conditions pertaining to employment or membership;

(2) The coverage is not available to the general public and can be obtained and maintained only because of the covered person's membership in or in connection with the particular organization or group;

(3) There are arrangements for bulk payment of premiums or subscription charges to the carrier; and

(4) There is sponsorship of the plan by the employer, union, association or trust.

(e) "Health insurance coverage" means a hospital or medical expense incurred policy, a nonprofit health care service plan contract, a health maintenance organization subscriber contract, or any other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise.

(f) "Health insurance coverage" shall not include one or more, or any combination of, the following:

(1) Coverage only for accident, or disability income insurance, or any combination thereof;

(2) Coverage issued as a supplement to liability insurance;

(3) Liability insurance, including general liability insurance and automobile liability insurance;

(4) Workers' compensation or similar insurance;

(5) Automobile medical payment insurance;

(6) Credit-only insurance;

(7) Coverage for on-site medical clinics; and

(8) Other similar insurance coverage, specified in federal regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Pub.L.No.104-191), under which benefits for medical care are secondary or incidental to other insurance benefits.

(g) "Health insurance coverage" shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the coverage:

(1) Limited scope dental or vision benefits;

(2) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or

(3) Other similar, limited benefits specified in federal regulations issued pursuant to HIPAA.

(h) "Health insurance coverage" shall not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether the benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(1) Coverage only for a specified disease or illness; or

(2) Hospital indemnity or other fixed indemnity insurance.

(i) "Health insurance coverage" shall not include the following if offered as a separate policy, certificate or contract of insurance:

(1) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;

(2) Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code; or

(3) Similar supplemental coverage provided to coverage under a group health plan.

(j) "Mental health provider" means any professional or institution listed under RSA 415:18-a, IV.

Ins 1906.03 Effective Date of Discontinuance for Nonpayment of Premium or Subscription Charges.

(a) If a policy or contract subject to this rule provides for automatic discontinuance of the policy or contract after a premium or subscription charge has remained unpaid through the grace period allowed for such payment, the carrier shall be liable for valid claims for covered losses incurred prior to the end of the grace period; and

(b) If the actions of the carrier after the end of the grace period indicate that it considers the policy or contract as continuing in force beyond the end of the grace period, such as, by continuing to recognize claims subsequently incurred, the carrier shall be liable for valid claims for losses beginning prior to the effective date of written notice of discontinuance to the policyholder or other entity responsible for making payments or submitting subscription charges to the carrier. The effective date of discontinuance shall not be prior to midnight at the end of the third scheduled workday after the date upon which the notice is delivered.

Ins 1906.04 Extension of Benefits.

(a) Every group policy, contract or certificate subject to this rule issued on or after the effective date of this rule, or under which the level of benefits is altered, modified or amended on or after the effective date of this rule, shall provide a reasonable provision for extension of benefits in the event of total disability at the date of discontinuance of the group policy, contract or certificate as required by the following paragraphs of this subsection.

(b) In the case of a group life plan that contains a disability benefit extension of any type (e.g., premium waiver extension, extended death benefit in event of total disability, or payment of income for a specified period during total disability), the discontinuance of the group policy, contract or certificate shall not operate to terminate the extension.

(c) In the case of a group plan providing benefits for loss of time from work or specific indemnity during hospital confinement, discontinuance of the group policy, contract or certificate during a disability shall have no effect on benefits payable for that disability or confinement;

(d) In the case of hospital or medical expense coverages other than dental and maternity expense, a reasonable extension of benefits or accrued liability provision is required.

(1) An extension of benefits or accrued liability provision will be considered "reasonable" if:

a. It provides an extension of at least 12 months under "major medical" and "comprehensive medical" type coverages; and

b. Under other types of hospital and medical expense coverages, it provides:

1. An extension of at least 90 days; or

2. An accrued liability for expenses incurred during a period of disability or during a period of at least 90 days starting with a specific event that occurred while coverage was in force, e.g., an accident;

(e) An applicable extension of benefits or accrued liability shall be described in any policy or contract involved as well as in group insurance certificates as follows:

(1) The benefits payable during any period of extension of benefits or accrued liability may be subject to the policy's, contract's or certificate's regular benefit limits, such as benefits ceasing at exhaustion of a benefit period or of maximum benefits for hospital or medical expense coverages, the benefit payments may be limited to payments applicable to the disability condition only.

(2) The benefit payments for hospital or medical expense coverages may be limited to payments applicable to the disability condition only.

Ins 1906.05 Continuance of Coverage in Situations Involving Replacement of One Carrier by Another.

(a) This subsection shall indicate the carrier responsible for liability in those instances in which one carrier's policy, contract or certificate replaces a plan of similar benefits of another carrier.

(b) After discontinuance of the policy, contract or certificate, the prior carrier remains liable only to the extent of its accrued liabilities and extensions of benefits. The position of the prior carrier shall be the same whether the group policyholder or other entity secures replacement coverage from a new carrier, self-insures, or foregoes the provision of coverage.

(c) If the individual was validly covered under the prior plan on the date of discontinuance, each individual who is eligible for coverage in accordance with the succeeding carrier's plan of benefits with respect to the class or classes or individuals eligible for coverage under the succeeding carrier's plan shall be enrolled and covered by the succeeding carrier's plan of benefits.

(1) Each person not covered under the succeeding carrier's plan of benefits in accordance with above, shall nevertheless be covered by the succeeding carrier in accordance with the following rules if the individual was validly covered, including benefit extension, under the prior plan on the date of discontinuance and if the individual is a member of the class or classes of individuals eligible for coverage under the succeeding carrier's plan. Any reference in the following rules to an individual who was or was not totally disabled is a reference to the individual's status immediately prior to the date the succeeding carrier's coverage becomes effective.

a. The minimum level of benefits to be provided by the succeeding carrier shall be the applicable level of benefits of the prior carrier's plan reduced by any benefits payable by the prior plan;

b. Coverage shall be provided by the succeeding carrier until the earliest of the following dates:

1. The date the individual becomes eligible under the succeeding carrier's plan as described in paragraph Ins 1906.05 (c);

2. For each type of coverage, the date the individual's coverage would terminate in accordance with the succeeding carrier's plan provisions applicable to individual termination of coverage such as at termination of employment or ceasing to be an eligible dependent; or

3. In the case of an individual who was totally disabled, and in the case of a type of coverage for which Ins 1906.04 of this rule requires an extension of benefits or accrued liability, the end of any period of extension or accrued liability that is required of the prior carrier by Ins 1906.04 of this rule, or if the prior carrier's policy, contract or certificate is not subject to that section, but would have been required of the prior carrier had the policy, contract or certificate been subject to Ins 1906.04 of this rule at the time the prior carrier's plan was discontinued and replaced by the succeeding carrier's plan.

(2) For health insurance coverage, in the case of an individual who was totally disability at the time the prior carrier's plan was discontinued and replaced by the succeeding carrier's plan, and in the case of which Ins 1906.04 of this rule requires an extension of benefits or accrued liability, the minimum level of benefits to be provided by the succeeding carrier shall be the applicable level of benefits of the prior carrier's plan reduced by any benefits paid by the prior plan.

(3) In the case of a preexisting conditions limitation included in the succeeding carrier's plan, the level of benefits applicable to preexisting conditions of individuals becoming covered by the succeeding carrier's plan in accordance with this paragraph during the period of time this limitation applies under the new plan shall be the lesser of :

a. The benefits of the new plan determined without application of the preexisting conditions limitation; or

b. The benefits of the prior plan.

(4) The succeeding carrier, in applying any deductibles or coinsurance amounts applicable to the out-of-pocket maximums or waiting periods in its plan, shall give credit for the satisfaction or partial satisfaction of the same or similar provisions under a prior plan providing similar benefits. In the case of deductible provisions or coinsurance amounts applicable to the out-of-pocket maximums, the credit shall apply for the same or overlapping benefit periods and shall be given for expenses actually incurred and applied against the deductible or coinsurance provisions of the prior carrier's plan during the 90 days preceding the effective date of the succeeding carrier's plan but only to the extent these expenses are recognized under the terms of the succeeding carrier's plan and are subject to a similar deductible or coinsurance provision.

(5) In any situation where a determination of the prior carrier's benefit is required by the succeeding carrier, at the succeeding carrier's request the prior carrier shall furnish a statement of the benefits available or pertinent information, sufficient to permit verification of the benefit determination or the determination itself by the succeeding carrier. For the purposes of this paragraph, benefits of the prior plan shall be determined in accordance with all of the definitions, conditions, and covered expense provisions of the prior plan rather than those of the succeeding plan. The benefit determination shall be made as if coverage had not been replaced by the succeeding carrier.

(d) Whenever there is a replacement of a carrier's benefit plan by the benefit plan of another carrier, the insureds, subscribers or members who were active recipients of mental health services under the prior

carrier's plan shall be entitled to continue to receive mental health services from the same mental health provider who provided the services received while the insured, subscriber or member was an active recipient of mental health services under the prior carrier's plan.

(e) The entitlement to receive services pursuant to (d) above shall:

(1) Continue for one year following the effective date of the new carrier's benefit plan;

(2) Override any provisions in the replacing carrier's plan requiring the insured, subscriber or member to receive mental health services from mental health providers who have contracted with the replacing carrier to be part of the replacing carrier's provider network;

(3) Override any provisions in the replacing carrier's plan that reduce or eliminate benefits for mental health services whenever such services are received from a mental health provider who has not contracted to be part of the replacing carrier's network;

(4) Be provided to any insured, subscriber or member who, during an open enrollment period, changed from a benefit plan sponsored by the employer to another benefit plan sponsored by the employer;

(5) Be subject to any provisions of the replacing carrier's plan requiring mental health services to be medically necessary, as defined in the replacing carrier's plan;

(6) Be subject to any provisions of the replacing carrier's plan requiring mental health services to be preauthorized by the replacing carrier or its utilization review agent;

(7) Be subject to the provision of proof of receipt of prior services while the prior carrier's plan was in effect as follows:

a. The insured, subscriber or member shall be responsible for providing such proof in the form of:

1. An explanation of benefits form from the prior carrier;

2. A letter from the provider who provided the services attesting to the fact that services were provided together with the dates such services were rendered; or

3. Any other documentation which the replacing carrier determines to be acceptable as proof.

(8) Be subject to verification that the provider of services under the prior carrier is protected by a malpractice policy with coverage of at least $1,000,000 per single incident and at least $3,000,000 in the aggregate.

(f) While the entitlement provided pursuant to (d) above is in effect, benefits shall be paid by the replacing carrier as if the insured, subscriber or member were receiving mental health services from a mental health provider who has contracted with the replacing carrier.

(g) The replacing carrier shall not be required to make direct benefit payments to a non-network provider nor shall this provision operate in any way to increase the liability of the replacing carrier above what

its liability would be if the mental health services were received from a contracting mental health provider who is reimbursed on a fee-for-service basis.

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